VERMONT ACADEMY OF FAMILY PHYSICIANS

Vermont Medical Society

Vermont Chapter
INCORPORATED IN VERMONT
American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

To : Secretary Jenney Samuelson, Agency of Human Services
Chair Owen Foster and Members of the Green Mountain Care Board
Chair Ginny Lyons, Senate Health & Welfare Committee
Chair Lori Houghton, House Health Care Committee
From: Jessa Barnard, Vermont Medical Society, jbarnard@vtmd.org
Date: May 14 , 2024
RE: Feedback regarding AHEAD Model

The Vermont Medical Society, Vermont Academy of Family Physicians and Academy of Pediatrics-Vermont Chapter submit these comments to inform next steps as Vermont transitions from the All-Payer Model when it comes to an end, likely at the end of 2025, and considers joining the Centers for Medicare and Medicaid Services (CMS) AHEAD Model that begins in 2026. We would like to thank AHS, the AHS Director of Health Care Reform, and the Green Mountain Care Board for soliciting and including physician feedback in developing plans for payment reform. Our organizations and members have participated in the Primary Care Workgroup[1] as well as the Global Budget Technical Advisory Group.[2]

We recognize that CMS has stated that they will no longer be negotiating individual state payment reform models and that Vermont securing Medicare participation in a payment reform model after 2025 is likely dependent on joining the AHEAD Model. We also recognize that the AHEAD Model only speaks to *Medicare's* participation in payment reform and that larger health care reform in Vermont can and will be broader than AHEAD, and can include Medicaid, private payers and other programs such as the Blueprint for Health. With these aspects in mind, we offer the following points for consideration in deciding whether to join the AHEAD Model, potential terms to negotiate with CMS and other concerns regarding assisting clinicians and health care practices in transitioning to a new payment reform model given the disruption that this will cause. Underlying all of these points is the importance of clinician and health care practice input as the model is negotiated with CMS and considered – and we request a continuation of opportunities for input, such as meetings of the Primary Care Workgroup, Global Budget TAG and robust provider representation on the AHEAD Model Governance Body.

Primary Care Payments

The AHEAD Model will make a $15-21 per-Fee for Service Medicare-beneficiary-per-month payment (PBPM) available to practices participating in the Model.[3] The average payment will be $17 PBPM, which promises an increased investment by Medicare in primary care.

[1] https://humanservices.vermont.gov/our-work/reports
[2] https://gmcboard.vermont.gov/global-budget-technical-advisory
[3] See slides 8-12 of the following presentation to the Primary Care Advisory Group comparing this monthly payment to Vermont's existing Blueprint and ACO payments: https://humanservices.vermont.gov/sites/ahsnew/files/documents/Primary%20Care%20Workgroup%20%235%20Slides_12.15.23_Summary_Final.pdf

While we welcome a new funding stream for primary care practices, at the same time, we highlight several concerns with the Model design for Vermont's primary care practices, many of which have been participating in Vermont payment reform programs for years:

- This payment will be adjusted upward or downward by CMS based on the State's performance on hospital participation goals and state Medicare FFS cost growth targets, factors over which primary care practices have little or no control.
- $17 PBPM is greater than most payments currently available to primary care, however this will only be linked to FFS Medicare patients, so the impact on each practice will be different – especially pediatric practices, which face losing all ACO payments while gaining very few dollars linked to Medicare payment. These payments are also not linked to Medicare Advantage plans, so as MA participation increases, payments to primary care will decrease.
- According to CMS's Notice of Funding Opportunity, after Year 4 of the Model, the payments will count towards the State's Total Cost of Care– so not only can they be adjusted downward if the State does not meet TCOC targets but the denominator of measurement will change after 4 years putting further downward pressure on the payments.
- Independent practices participating in OneCare's capitated Comprehensive Primary Care program, stand to lose 105% FFS rates for "non core" services as well as a steady, predictable income stream. In our understanding, CMMI has held firm to not introducing a capitated payment model sooner than 2027.
- CMMI is currently indicating that the AHEAD Model will not count as an Advanced Alternative Payment Model[4] under CMS's Merit-based Incentive Payment System (MIPS). MIPS ties physician's Medicare payments to their individual, group practice or alternative payment model (APM) score on reported and applicable: (1) quality measures, (2) cost measures, (3) health IT use and (4) practice improvement activities. Participating in OneCare Vermont has qualified as participating in an Advanced Alternative Payment Model and led to an exemption from MIPS. Critiques of MIPS include that is it costly, administratively burdensome, exacerbates health inequities, and hurts rural and independent practices.[5] By one estimate, compliance with MIPS costs $12,800 per physician per year and physicians spend 53 hours per year on MIPS-related tasks. These 53 hours are equivalent to a full week of patient visits.
- While CMMI is dedicating additional resources to primary care through this Model, CMS's Medicare fee for service Physician Fee Schedule continues to decrease year over year with the effect of the fee schedule being reduced 26% adjusted for inflation from 2001–2023.[6]
- Regardless of the potential strengths of the Model, it will be disruptive for primary care practices – especially if it also comes with the end of a statewide ACO - leading each practice to need to assess the financial impacts of participation, adopt new administrative requirements such as entering contracts with CMMI and individual payers, and change quality/data collection methods and targets.

Due to these concerns, our organizations request the following:

- Primary care practices should not be subject additional administrative burden for, by example, subjecting them all to the Medicare's Merit-based Incentive Payment System (MIPS). Vermont should prioritize in negotiations with CMS obtaining a MIPS exception for participating in AHEAD. Absent securing this exception, AHS should support all possible State-based paths forward for a MIPS exception, such as supporting the creation of a Medicare Shared Savings

[4] https://qpp.cms.gov/apms/advanced-apms
[5] https://www.ama-assn.org/practice-management/medicare-medicaid/medicare-basics-series-merit-based-incentive-payment-system
[6] https://www.ama-assn.org/system/files/ama-medicare-reform-grassroots-insert.pdf

Program ACO[7] or developing a state-based Advanced Payment Model.

- Vermont should also prioritize in negotiations with CMS a predictable, stable PBPM payment that does not vary based on statewide hospital and total cost of care targets nor should the payment be included in a TCOC measure starting in Year 4. Absent securing this in negotiations with CMS, AHS should plan for mitigating year to year fluctuations in this payment to primary care practices, such as guaranteeing that the payment will not decrease from the level set in Performance Year 1 (2026), which might require backfilling funding through state mechanisms such as Medicaid or Blueprint payments. If private payers participate in the model, a consistent PBPM payment should be set.
- All primary care practices, but particularly independent and pediatric practices currently participating in Vermont's existing payment reform activities such as OneCare Vermont's Comprehensive Payment Reform (CPR) and Population Health Management Payments must be held harmless – if not additionally supported – with the transition to the AHEAD Model. AHS should continue to advocate for a capitated payment model for primary care beginning in 2026. CMS is already developing models that move in this direction, such as the ACO Flex Model.[8] Also, agreeing with AHS that AHEAD does not encompass all of health reform, this means that AHS must consider what it can do directly to assist with the transition to a new payment model for these practices, including but not limited to developing Medicaid capitated primary care payments, matching the Medicare PBPM payment with Medicaid, addressing what primary care payments look like from commercial payers and increasing Blueprint Patient Centered Medical Home Payments, as recommended by the Act 51 of 2023 report completed by the Blueprint for Health regarding PMPM payments to patient centered medical homes.[9]
- AHS should address in negotiations with CMS how CMS will assist in securing participation in the Model by Medicare Advantage plans. CMS has told states that they are expected to encourage MA plan participation while states have little to no leverage or regulatory authority over MA plans.
- With the likely loss of an ACO, it is unclear what entity will take the lead on assisting practices in understanding the components of the AHEAD Model and completing the fiscal analyses, contracting, quality/data and other administrative requirements necessary for successful participation in the AHEAD Model. The State's AHEAD Application indicates some support by Blueprint for Health staff and quality improvement facilitators, but these individuals would likely focus more on clinical transformation than providing the detailed financial modeling that may be necessary to determine the impacts of participation. Just as AHS proposes to support hospitals with individual financial technical assistance, primary care practices must be provided fiscal impact analysis and support. AHS must make a plan for what entity will take the lead in these tasks and how this work will be funded.

---

[7] https://www.cms.gov/medicare/payment/fee-for-service-providers/shared-savings-program-ssp-acos/about; see also the presentation to the Primary Care Advisory Group, explaining how an MSP ACO could operate concurrently with the AHEAD Model. https://humanservices.vermont.gov/sites/ahsnew/files/documents/Primary%20Care%20Workgroup%20%235%20Slides_12.15.23_Summary_Final.pdf

[8] https://www.cms.gov/priorities/innovation/innovation-models/aco-primary-care-flex-model

[9] See https://blueprintforhealth.vermont.gov/sites/bfh/files/documents/Blueprint_Act51_Report_on_PCMH_Payments_final.pdf. The report concludes that to sustain the program, the legislature could create parity between Medicaid and commercial insurers by (1) Increasing the commercial insurer PCMH payment to $4.65 through a two-year increase of $0.83 in FY2025 and $0.82 in FY2026; and (2) With input from the Department of Financial Regulation, implementing legislative clarification of contributions by third-party administrators of self-funded plans and a renewed focus on engaging all commercial insurers in all Blueprint initiatives. We request that the Committee move forward with these recommendations in H. 151, consistent with a multifaceted approach to supporting primary care in Vermont.

- CMMI should partner with participating states to advocate internally to CMS to ensure adequate Medicare fee schedules for the health care system. The impact of one model increasing payment while another is cut undermines any progress.
- Access to Medicare data is also a concern for participating practices, and AHS should address in negotiations with CMS the ability for primary care practices to obtain and review for accuracy any Medicare patient data used for attribution, quality or performance metrics.
- AHS should continue to convene the Primary Care Advisory Group to both share developing information regarding the Model and solicit input regarding implementation – and should also seek far more than the minimum indicated in the State's application of 1 primary care clinician participating on the Model Governance Body.

Primary Care Spend Target

The AHEAD Model will require participating states to establish and meet an all-payer primary care investment target. A state can set their own definition of primary care for measurement or use a CMS definition. Vermont's application indicates a plan to use a Vermont-specific definition based off of one developed by the New England States Consortium Systems Organization. Our organizations have for a number of years supported setting a statewide primary care spend target with the goal of increasing investment in primary care[10] and participated in the DVHA and GMCB workgroup to define primary care services and analyze primary care spending in Vermont.[11]

While supporting the general direction of the AHEAD Model and application in setting a primary care spend target, there remain a number of important decisions to be made such as setting the actual target amount, which levers to use to direct additional funding to primary care services, and whether funding should be directed to specific uses or purposes. The application indicates an intent to use the Blueprint program as the mechanism and program direction – but many details remain, including how the GMCB and AHS will coordinate to accomplish these goals.

Our organizations suggest the following:

- As mentioned above, the Model Governance Body - which is charged with informing the primary care spending target – include robust participation from primary care clinicians and organizations. AHS continue to convene a Primary Care Subgroup and seek their input on primary care spend methodologies and targets.
- AHS, the GMCB and the legislature further clarify and define the roles and lines of responsibility and communication between AHS and the GMCB when it comes to health care reform generally and primary care innovation specifically. This should include which entity/entities will lead, support or collaborate on setting a primary care spend target and methodology; what entity will negotiate with payers (Medicaid, Medicare, commercial) to set contract terms, targets, and funding; how these decisions will be incorporated into the GMCB's current insurance and hospital rate regulation systems; and clarifying the role of the Model Governance Body in setting the primary care target. The lead entity should be required to consult with primary care clinicians and professional associations in developing the target and methodologies.

Hospital Sustainability

Many of our members work at, and all rely on the ability to make referrals to, a stable and accessible

[10] https://vtmd.org/client_media/files/2021_Call_to_Prioritize_Primary_Care.pdf
[11] https://legislature.vermont.gov/assets/Legislative-Reports/Act-17-Primary-Care-Spend-Report-15-January-2020_Final.pdf

hospital system that includes specialty, tertiary and emergency care. We support the ongoing work of a Technical Advisory Group, including clinician participation and input, to develop a Global Budget Methodology and provide input on whether to, and the terms of, entering into any agreement with CMS. Negotiations with CMS should work towards, and the state should only enter an agreement with CMS, if the global budget meets the Hospital Global Budget Technical Advisory Group (TAG) goals[12] that a hospital global budget:

- Create financial predictability and sustainability for hospitals to have the workforce and capital investment resources needed to meet the needs of the communities they serve;
- Create a payment model that supports delivery of the right care, in the right place, and at the right time;
- Support and incentivize increased efficiency in administration and clinical care by reducing – and when possible, eliminating – unnecessary costs and effort associated with administrative processes.

As discussed in the AHEAD application, Vermont already has a history of being a low-cost Medicare state and achieving savings in the Medicare program without seeing those savings reinvested in the State's health care system. Ongoing downward budgetary pressures can continue to exacerbate Vermont's access issues. Not only is there challenge accessing primary care, but a well documented concern in the state is the wait time for certain specialty services, with patients experiencing the longest waits for services such as dermatology, neurology, psychiatry and endocrinology.[13] If Vermont is not able to negotiate a sustainable global budget or capture savings to support the ability to hire and retain both primary care and specialty clinicians it will hamstring efforts to have the workforce needed to prevent higher cost admissions, address wait times and more.

Our organizations also recognizing the shortcomings of the AHEAD Model in supporting other critical partners in our health care system needed to prevent hospitalization and facilitate timely discharge and recovery after illness, such as home health, mental health and long term care. We support further work with AHS and the GMCB to ensure that these partners in our health care system are supported and that financial incentives and regulatory structures facilitate rather than inhibit coordination and resource sharing. CMS waivers may help support this work.

Thank you for considering our feedback as Vermont considers whether to join the AHEAD Model. We look forward to continued partnership on these issues and please reach out any time to discuss further.

[12] https://gmcboard.vermont.gov/sites/gmcb/files/documents/TAG%20Meeting%2015%2020240229-1.pdf (see slide 31).
[13] https://dfr.vermont.gov/sites/finreg/files/doc_library/vermont-wait-times-report-021822.pdf